Volume 2 Issue 3

Summer 2002

Communicable Disease Control UPDATE

MECKLENBURG COUNTY HEALTH DEPARTMENT

CD Control

Foodborne Disease

Approximately 76 million cases of foodborne disease occur each year in the United States. Most illnesses are mild but 325,000 persons are hospitalized and 5200 die as a result of foodborne illness each year. There were 1344 reported outbreaks of foodborne disease in the United States in 1999. Outbreaks were caused by bacteria, viruses, parasites and chemicals (natural and man-made). Many of the infectious foodborne illnesses are the result of food contaminated with human or animal feces.

More than 250 different foodborne illnesses are known and new pathogens continue to emerge. When pathogens that are known to cause serious illness are isolated in a patient, North Carolina law **requires the laboratory and physician to report the case to the local health department**. Reportable foodborne diseases include *Salmonellosis*; *Campylobacter* infection; *E. coli* (shiga-toxin producing) infection; *Listeriosis*; *Shigellosis*; *Cyclosporiasis*; *Yersiniosis*, *Scombroid Fish Poisoning*, etc.

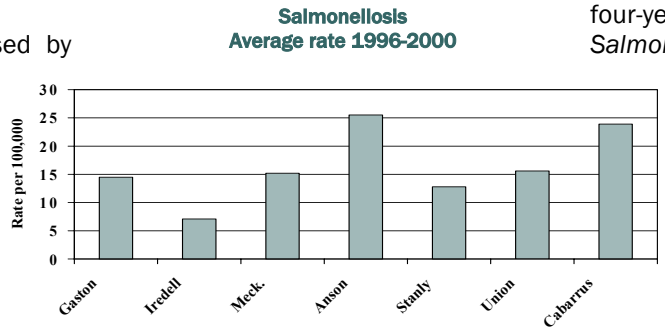
The proportion of illness caused by fruits and vegetables is increasing in the US. *E. coli 0157:H7* infection has been linked to fecally contaminated lettuce and coleslaw. Parsley imported from Mexico resulted in an outbreak of *Shigella* in 1998. Outbreaks of *Salmonella* have been linked to alfalfa spouts and unpasteurized orange juice. Raspberries imported from Guatemala resulted in an outbreak of *Cyclospora* in 1996. An outbreak of hepatitis A was traced to frozen strawberries.

The incidence of 3 bacterial foodborne outbreaks has dropped in the U.S. since 1996 (*Campylobacter* 27% decrease; *Listeria* 35% decrease; *Salmonella* 15% decrease). *E. coli 0157:H7* has decreased 21% since 2000. Other less common bacterial foodborne illnesses have also declined since 1996 (*Yersinia* 49% decrease; *Shigella* 35% decrease).

There were two restaurant related outbreaks of *Salmonella* in 1999 in Mecklenburg County. In 1999, the Health Department investigated 246 complaints about restaurants.

In 2000 an outbreak of *Listeriosis* affecting 12 Hispanic residents, including 10 pregnant women occurred in Forsyth County, NC. The *Listeria* outbreak was traced to homemade Mexican-style cheese made from contaminated raw milk from a local dairy. Over 200 persons became ill with *E. coli 0157:H7* infection in Robeson County, NC last December after consuming homemade butter made with unpasteurized milk. An outbreak of *Salmonella* in Mecklenburg County last year was traced to a restaurant that was operating without adequate refrigeration.

Most of the reportable foodborne illnesses that are investigated by the Mecklenburg County Health Department are sporadic and not part of an outbreak. There has not been a significant change in the reported incidence of *Salmonella* in Mecklenburg County in recent years. The incidence of *Yersinia*, *Listeria*, and *Scombroid Fish Poisoning* has remained low. The incidence of *Campylobacter* and *Shigella* has decreased in the last 10 years in the county. There was a decrease in the incidence of reported *E. coli 0157:H7* cases in 2001 in Mecklenburg County (2.7 per 100,000 population in 2000; 0.1 per 100,000 population in 2001). A comparison of four-year average incidence rates for *Salmonella* in seven counties in our area revealed the highest rates were in Anson and Cabarrus counties (see Table).



For more information contact Jane Hoffman at 704.336.5490 or hoffmlj@co.mecklenburg.nc.us

West Nile Virus...

The state testing lab will only accept American crows, blue jays and raptors for testing for WNV. The birds cannot be decomposed or mangled and cannot be tested if they have been dead for more than 36 hours unless they have been refrigerated. To report dead birds that meet these qualifications, call 704.353.0350.

Influenza 2002—2003

The Advisory Committee on Immunization Practices (ACIP) recommends yearly flu vaccines for the following groups of people: persons aged > 50 years; residents of nursing homes and other long term care facilities; adults and children with chronic pulmonary or cardiovascular disorders, including asthma; adults and children who require regular medical care or hospitalization because of chronic metabolic diseases including diabetes, renal dysfunction, hemoglobinopathies or immunosuppression; children and adolescents receiving long tern aspirin therapy who might be at risk for developing Reye syndromes after influenza infection; women in their 2nd or 3rd trimester of pregnancy during the influenza season; and health-care workers and others in close contacts with persons at high risk, including household contacts. In addition to the above groups, influenza vaccine can also be given to any person 6 months of age or older to reduce the probability of becoming infected with the influenza virus.

The optimal time to vaccinate is during October and November. The ACIP is recommending that providers focus their October vaccination efforts on health care workers, high-risk persons and their household contacts, and healthy children aged 6-23 months during this time frame because of the history of vaccine distribution delays during the previous two seasons. Children under 9 years of age who receive the vaccine for the first time will need two doses administered one or more months apart and should begin vaccination in October. Vaccination of all other groups should begin in November and continue into December and later depending on vaccine availability.

The influenza vaccine and the pneumococcal vaccine can be administered in different sites at the same time without increasing side effects. This approach should be considered in the high- risk patient who presents for influenza vaccine who has not previously received the pneumococcal vaccine.

This season's trivalent vaccine virus strains are A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Hong Kong/330/2001-like strains. A limited amount of the vaccine with reduced thimerosal content will be available for the 2002-2003 season.

For more information, contact Gail Mills at 704.353.1270 or millsgb@co.mecklenburg.nc.us

MSM - High Risk for Hepatitis A

Outbreaks of Hepatitis A in men who have sex with men (MSM) have been documented in large cities in the United States, Europe and Australia in recent years. Data from serological studies revealed that the risk of Hepatitis A infection is several-fold higher among MSM than among control populations. In serological studies of MSM, men with antibodies reported more frequent oral-anal contact, longer duration of homosexual activity, and a larger number of sexual partners than persons without serological evidence of Hepatitis A infection. These outbreaks led the ACIP to recommend in 1995 that MSM should receive hepatitis A vaccination.

The five counties with the highest average number of reported cases of Hepatitis A in North Carolina from 1997-2001 were Mecklenburg, Wake, Forsyth, Guilford and Buncombe. During the first five months of 2002, 118 cases of Hepatitis A were reported in North Carolina residents. Male homosexual contact was reported in a higher proportion of the 2002 cases as compared to earlier years. Of the reported cases in males in North Carolina between January – May, 2002, one-third self-reported recent sexual contact with men.

In 2001, 47 residents of Mecklenburg County were reported as having Hepatitis A (analysis done by report date- not onset date). This was a substantial increase from the 10 reported cases in 2000. Thirty percent of reported cases in Mecklenburg residents in 2000 and 2001 were MSM.

Physicians are asked to recommend and offer Hepatitis A vaccine to MSM. Pre-vaccination testing is not indicated for adolescents and young adults but might be warranted in older men. The hepatitis A vaccine is a series of two immunizations given over six months. Hepatitis A vaccine is available at the Mecklenburg County Health Department for a fee. The appointment line number is 704.336.6500.

For further information, contact Jane Hoffman at 704. 336.5490 or hoffmlj@co.mecklenburg.nc.us

Did you know...

...the North Carolina Commission for Health Services adopted some changes to the communicable disease rules effective February 15, 2002? Changes include diseases that are reportable, control measures for HIV and Hepatitis B and laboratory requirement issues? The revised rules are available at http://www.epi.state.nc.us/epi/gcdc.html

...there were 1,402 reported cases of malaria in the United States in 2000 including 6 deaths? North Carolina reported 36 cases of malaria in the same year including one case of congenital malaria.

Congenital Varicella Syndrome

Pregnant women who have never had chickenpox (varicella) are at risk of getting chickenpox during pregnancy. A small percentage of women who get chickenpox during pregnancy will deliver babies with birth defects, known as "congenital varicella syndrome". These birth defects could consist of limb atrophy and scarring of the skin of the extremity as well low birth weight, seizures, mental retardation, and cataracts. The risk of birth defects is relatively low (0.4% for infection 1-12 weeks of pregnancy and 2.0% for infection 13-20 weeks of pregnancy). Pregnant women may also have a more severe form of chicken pox, putting her at risk of severe complications. The most effective way to protect a susceptible pregnant woman from getting chickenpox is to vaccinate her close contacts.

Questions and answers relating to chickenpox and pregnancy:

What if a pregnant woman is exposed to someone who has chickenpox?
Varicella Zoster Immune Globulin (VZIG) is recommended for any pregnant woman who is susceptible to varicella and has been exposed to a person with the disease *in the previous 96 hours.*

Will VZIG prevent birth defects in the newborn?
Although treatment with VZIG is considered to be safe, it has not been determined if it will prevent congenital varicella syndrome. It does prevent severe complications of varicella in a susceptible pregnant woman.

What if the pregnant woman isn't sure if she had chickenpox in the past?
Any pregnant woman who does not have a clear history of having had chickenpox, and has had close contact with an infected person, should have her blood drawn and tested for the varicella antibody. All pregnant women who have never had chickenpox should be told to notify their physician's office immediately if they come in contact with an infected person.

Is there a time limit for getting the VZIG?
Yes. VZIG is only effective if given within 96 hours of exposure to varicella; therefore, the constraints of time may make testing impractical.

How long does the protection from VZIG last?
Duration of protection is unknown, but should last at least the half-life of the VZIG, which is approximately 3 weeks. Susceptible pregnant women who are exposed again after 3 weeks should receive another full dose of VZIG. As soon as a woman delivers her baby, she should be vaccinated against varicella. The second varicella dose can be given at her 6 week postpartum visit.

What can be done for the baby if the mother gets chickenpox during pregnancy?
If the mother develops chickenpox within 5 days before, or 48 hours after delivery, the newborn should be given VZIG (even if the mother received VZIG during pregnancy). VZIG can prevent or modify clinical varicella if given shortly after exposure.

Where do you get the VZIG?
VZIG can be ordered from FFF Enterprises Customer Service Line at 888.843.7477. The drug is quite expensive, with an average dose costing around $600. *As of May, 2000, it is no longer available from the American Red Cross.*

For more information contact Nancy Hill at 704.336.5498 or hillnd@co.mecklenburg.nc.us

References:
1. CDC. Varicella Vaccine Related to Pregnancy. 2002.
2. CDC. Facts About Chickenpox (Varicella). May, 16, 1997
3. Public Health Service *ACIP Statement on Varicella Prevention*, *MMWR, July 12, 1996, Vol. 45, No. RR-11.*
4. Behrman, R.E., & Kliegman, R. (1990). Nelsons Essentials of Pediatrics (W. B. Saunders Co). p 354.

FAQ

Q. How should I advise my patients to dispose of their used needles?

A. According to Ann Gill from Mecklenburg County Solid Waste Management, the best way to dispose of any sharps is to place it in a rigid plastic container that has a lid, like a bleach bottle or a liquid detergent bottle. Ann also adds that medication should never be poured down the drain or flushed. Pills should be dissolved in water, mixed with kitty litter and placed in the regular trash. Liquids should be mixed into kitty litter and placed in the trash.

Q. After receiving the Varicella vaccine, how long should a woman wait to become pregnant?

A. The ACIP and AAP recommend that a woman not become pregnant for at least one month following each dose of the vaccine. The package insert recommends a 3 month delay

Q. What malaria prophylaxis should be prescribed for a patient traveling to South America?

A. The Centers for Disease Control and Prevention (CDC) recommends that travelers who plan to visit countries where malaria is endemic check out their website at www.cdc.gov. Specific medical information for each country can be obtained. Patients can visit a travel clinic or their private provider for appropriate prescriptions and immunizations.

Human Rabies Post-Exposure Treatment

Rabies is an acute viral disease that affects humans, primates, and most warm-blooded animals. Rabies when acquired by humans is uniformly fatal. The virus is most often transmitted from an infected animal by means of a deep bite/puncture wound or by the animal licking an open wound, abrasion, or mucous membrane. The virus then travels by the peripheral nerves to the central nervous system to the brain stem and then into the brain. Once inflammation of the brain occurs, every neuron in the brain becomes infected.

The prodromal phase lasts from a few days to 2 weeks and includes malaise, headache, fever, and usually pain or numbness at the site of entry (bite). An acute neurological phase lasting from 2 to 7 days follows with excitability, hydrophobia, manic behavior, excessive salivation, and lethargy along with paralysis, delirium and convulsions. The end stage disease lasts about 10 days, begins with coma, and ends in vascular collapse and respiratory cessation.

For humans to survive an encounter with a suspected or laboratory-confirmed rabid animal, medical treatment must begin without delay. The treatment consists of a combined therapy using rabies immunoglobulin and one of the three vaccines available for humans.

The Rabies Immune Globulin (RIG) provides immediate circulating antibodies that have a half-life of 21 days and is given only once on the first visit to the doctor. When this passive immunity ends, seroconversion of the vaccine has already begun to produce antibodies that provide a titer of active immunity for the patient.

All post-exposure treatment should begin with a thorough cleansing of all wounds with soap and water. If anatomically feasible, the full dose of RIG should be infiltrated around the wound and any remaining volume should be administered IM at a site as far away from the vaccine site (the deltoid) as possible. Fingers or other nonmuscular sites should not be used.

Human Diploid Cell Vaccine, Rabies Vaccine Adsorbed, and Purified Chick Embryo Cell Vaccine are all available and all are given intramuscularly in 1.0-milliliter doses in the upper deltoid muscle of either arm. The Human Diploid Cell is the most often used of these vaccines and is given on day 0 (first visit to the doctor) followed by a single shot on days 3, 7, 14, and 28 for a total of five shots. This vaccine induces an active immune response producing neutralizing antibodies. Antibody response begins in about seven days and will persist for approximately two years.

The following dosage schedule should be adhered to as closely as possible:

Human Rabies Immune Globulin (HRIG) — **1 dose on first visit only**

Human Diploid Cell Vaccine (HDCV) — **1 shot on first visit to doctor and one shot each on days 3, 7, 14, and 28 for a total of 5 shots.**

Post-exposure rabies prophylaxis is not available at the Mecklenburg County Health Department.

Research has shown that patients who are immunosuppressed or immunocompromised may not develop adequate rabies antibody titers while taking chemotherapy for other illnesses such as malaria, HIV/AIDS or cancer. Those patients should be vaccinated intramuscularly and checked for antibody response. Immunosuppressive drugs should not be administered to these patients unless absolutely necessary to treat their pre-existing illness. Systemic, anaphylactic, or neuroparalytic reactions are rarely associated with post-exposure rabies treatment, but if encountered, consultation with the Health Department and the Centers for Disease Control and Prevention is advised. Post-exposure rabies shots are not contraindicated in pregnancy since research has shown that no fetal damage has been associated with its usage.

For more information, contact Al Piercy at 704.336.6440 or piercaw@co.mecklenburg.nc.us

References:

1. Libby, John, and Harvey W. Meislin. "Human Rabies." Annals of Emergency Medicine April 1983: 217 - 220.
2. "Human Rabies Prevention—United States, 1999. Recommendations of the Advisory Committee on Immunization Practices (ACIP)." CDC, Centers for Disease Control and Prevention. MMWR Morbidity and Mortality Weekly Report. Vol. 48. No. RR-1. January 8, 1999.

Td Shortage Over

The supply of adult tetanus and diphtheria toxoids (Td) is now sufficient to permit resumption of the routine schedule for Td use. This announcement came from the CDC in the June 21, 2002 edition of the MMWR. Adolescents and adults who had their routine Td booster deferred should be recalled to receive the delayed dose. School attendance provisions requiring a Td booster at or after the age of 11 years will be reinstituted.

The Td shortage, which began in late 2000, resulted from decreased production by U.S. manufacturers. This was compounded by the decision of one manufacturer to cease production in 2001. The 11-month period required for vaccine production from the remaining manufacturer led to a lag before increased Td supplies were available. Health-care providers should now review the vaccination status of their patients and administer Td as appropriate.

For more information contact Beth Quinn at 704.336.5398 or quinnes@co.mecklenburg.nc.us

4 Day Rule and Other Good Things

North Carolina Commission for Health Services has amended the current North Carolina Administrative Code relating to the immunization rules (15A NCAC 19A.0401). These changes will bring the immunization requirements in line with the revised Advisory Committee on Immunization Practices (ACIP) general recommendations on immunizations. The following changes are effective May 17, 2002:

⇒ An individual who has reached his/her fiftieth birthday shall not be required to receive rubella vaccine **except in outbreak situations**. An individual who entered college after his/her thirtieth birthday and before February 1, 1989 shall not be required to meet the requirement for rubella vaccine **except in outbreak situations.**

⇒ The third dose of hepatitis B vaccine shall not be administered prior to 6 months of age**. If the vaccine is given up to and including the fourth day prior to the required minimum age the individual dose will not be required to be repeated.** Doses given more than 4 days prior to the requirements are considered invalid and shall be repeated.

⇒ Healthcare providers shall administer all immunizations in accordance with the rules**. However if a vaccine is given up to and including the fourth day prior to the required minimum age, the individual dose will not be required to be repeated.** Doses given more than 4 days prior to the requirements are considered invalid and shall be repeated.

The intent of this rule change is to allow doses **inadvertently** given as much as four days early to be counted as valid during a record review and should not be used to schedule early immunization visits or conveniently administer vaccines earlier than the requirement. For questions, please contact Betty Zusin at 704.336.5076 or zusinbl@co.mecklenburg.nc.us

HBIG

There are several types of situations when a contact to a hepatitis B patient should receive hepatitis B immune globulin (HBIG). Infants born to HBsAg positive mothers should be given a single dose of HBIG (0.5 ml IM) **and** vaccine within 12 hours of birth. When an *acutely* infected person is a primary caregiver of a susceptible infant less than 12 months of age, the infant should receive an appropriate dose of HBIG. After percutaneous or permucosal exposures to blood that contains or might contain HBsAg, HBIG should be given as soon as possible, but at least within 24 hours after high risk needle stick exposure, and the hepatitis B vaccine series should be started. *(Guidelines are dependent on exposed persons immunization status and whether or not they are known responders)*. After sexual exposure to a person with acute HBV infection, a single dose of HBIG (0.06 ml/kg) is recommended if it can be given within 14 days of the last sexual contact. For all exposed sexual contacts of persons with acute and chronic HBV infection, vaccine should be administered.

Some sources for HBIG are as follows:
FFF Enterprises:
1.800.843.7477 ask for customer representative
NABI Biopharmaceuticals:
1.800.458.4244
24-hour cell phone contact:
561-307-2335
24-hour pager contact:
1-888-415-4795
CT International:
1.800.755.7575
Hours: Monday- Friday 6 am. to 5 pm.
Bayer Pharmaceuticals:
1.800.288.8370
Hours: Monday- Friday 8 am to 5 pm
For more information, contact Monica O'Lenic at 704.336.6436 or olenimt@co.mecklenburg.nc.us

Reference: Chin, James, MD, MPH, Editor. (2000) 17th edition. *Control of Communicable Disease Manual.* P.243-251.

A History Lesson

Meriwhether Lewis , the famous Lewis of the daring adventure team Lewis and Clark, had it. So did Al Capone, America's best known gangster. Lord Randolph Churchill, father of Sir Winston, and Pope Alexander VI, pope from 1492—1503, had it but didn't want anyone to know about it. Friedrich Nietzsche, the 19th century German philosopher and writer was driven insane and died from it. Scott Joplin, the early ragtime composer and musician also died from it. King Edward VI, King of England from 1547—1553 was born with it—a gift from his infamous father, King Henry the VIII. Even Florence Nightingale had it.

Syphilis has been around for centuries. The two most notable epidemics occurred at the end of the 15th century in Europe after World War II in the United States.

For questions about syphilis or any sexually transmitted disease, call the hotline at 704.432.TEST (8378).

Contributed by Mike Rogers, DIS.

Source: www.medinfo.ufl.edu and www.wikipedia.com

Reporting Communicable Diseases – Mecklenburg County

To request N.C. Communicable Disease Report Cards, telephone 704.336.2817

Mark all correspondence "CONFIDENTIAL"

Tuberculosis:

TB Clinic 704.921.6170
Mecklenburg County Health Department FAX 704.921.6133
251 Eastway Drive
Charlotte, NC 28213

Sexually Transmitted Diseases, HIV, & AIDS:

Regional Office HIV/STD Surveillance 704.336.6480
Mecklenburg County Health Department FAX 704.336.6200
700 N. Tryon Street, Suite 214
Charlotte, NC 28202

All Other Reportable Communicable Diseases including Viral Hepatitis A, B & C:

Report to any of the following nurses:

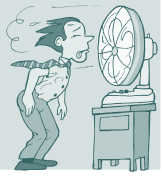
Nancy Hill, RN, 704.336.5498
Jane Hoffman, RN, 704.336.5490
Lorraine Houser, RN 704.336.6438
Gail Mills, RN 704.353.1270
Monica O'Lenic, RN 704.336.6436
Elizabeth Quinn, RN 704.336.5398
Communicable Disease Control FAX 704.353.1202
Mecklenburg County Health Department FAX 704.432.0267
700 N. Tryon Street, Suite 271
Charlotte, NC 28202

Animal Bite Consultation / Zoonoses / Rabies Prevention:

Al Piercy, RS 704.336.6440
Communicable Disease Control FAX 704.353.1202
Mecklenburg County Health Department FAX 704.432.0267
700 N. Tryon Street, Suite 271
Charlotte, NC 28202
or State Veterinarian, Lee Hunter, DVM 919.733.3410
State after hours 919.733.3419

Suspected Food borne Outbreaks / Restaurant, Lodging, Pool and Institutional Sanitation:

Food & Facilities Sanitation 704.336.5100
Mecklenburg County Health Department FAX 704.336.5306
700 N. Tryon Street, Suite 208
Charlotte, NC 28202



Mecklenburg County Health Department

Distribution of Potassium Iodine

On June 12th, President Bush announced that the Federal Government would make potassium iodine (KI) available to each State as part of the Public Health Security and Bioterrorism Response Act of 2002 (H.R. 3448). This provision was made in an effort to protect American citizens from radionuclides released during terrorist acts such as an attack on a nuclear power plant, nuclear bomb detonation, or explosion of a "dirty bomb." States are then to formulate their own policies and procedures as to how and when to distribute the KI. Many state political and health officials are having difficulty deciding whether or not to accept the KI, and if they do accept, the best way to distribute it to their citizens.

Increasing the availability of KI to citizens of the US seems a reasonable use of public health resources on face value; however, many decision makers are grappling with the efficacy of this proposition. Potassium iodine has been shown to be somewhat effective in preventing thyroid cancer resulting from inhalation and/or ingestion of the radionuclide, Iodine-131 (I-131). Radioactive Iodine-131 concentrates in the thyroid, because it mimics the more common, non-radioactive forms of Iodine (e. g., I-127) that are used to form hormones involved in the control heart rate, body temperature, and growth. This latter function is one of the reasons children are particularly susceptible to the carcinogenic effects of I-131 -- a child's thyroid takes up Iodine more readily to support their development. If taken prior to or soon after a release of radioactive I-131, potassium iodine will reduce the uptake of I-131 by saturating the thyroid with non-radioactive Iodine.

If KI is protective against the harmful effects of I-131, then why should there be deliberation about its distribution? First, I-131 is only one of many radioactive elements that would be present in a radiation release event. Cesium-137, Strontium- 90, Cobalt-57, Uranium-238, and Thorium-234 are a few of the radionuclides that also could be present. Therefore, body organs other than the thyroid will be impacted. Public health officials worry that citizens will develop a false sense of security as a result of their taking KI. Potassium iodine may be helpful against developing thyroid cancer resulting from I-131 exposure, but it will not protect against the harmful effects of other radionuclides.

Further, reports of the Chernobyl nuclear power plant accident in 1986 found thyroid cancer in children was the only credible health effect associated with the subsequent radiation contamination. These reports suggest that large components of society may not benefit from being supplied KI. Most health officials studying the health effects of the Chernobyl accident agree that the adverse effects of consuming KI were few and minimal; however, a small number of individuals may be allergic or sensitive to iodine and experience adverse reactions.

The most effective form of protection from radiation releases is evacuation. This protection results from 3 factors that will affect an individual's radiation exposure: distance, dilution, and time. Radiation energy decreases the further away a person is from a source. A common example of this phenomenon is the loss of light intensity from a flashlight when trying to illuminate objects further away. Dilution of the concentration of radionuclides will increase with distance from a source. Radionuclide particles separate over distance as a result of wind turbulence and physical and chemical properties of the radionuclides. As particles separate, the space between them is filled with uncontaminated air. Therefore, the concentration of radionuclides will decrease over distance, making the air less harmful further from the source. Finally, radiation exposure is cumulative; thus, the longer a person is exposed to radioactive sources, the more likely they will suffer harmful effects. The amount of time individuals are exposed to radioactive materials should be as short as possible.

These are a few of the issues politicians and health officials are deliberating as they decide if they should accept and distribute potassium iodine. Many difficult questions arise, for example: Will the health benefits of distributing KI outweigh the costs associated with storage, transportation, materials, supplies, and manpower needed for an effective distribution program? What other health programs should be cut or reduced to allow for these resources? How can the distribution be tracked? But the most important question is, Will people develop a "false sense of security" if they take KI and not evacuate from a contaminated area in a timely manner – that is, will people ignore or delay evacuation because they feel safe as a result of taking KI? These are not easy questions to answer and will require serious consideration and debate that will involve social values as well as scientific evidence associated with the issues that arise.

For more information, contact Robert J. Kennedy at 704.432.1972 or kennerj@co.mecklenburg.nc.us

Editor's Note: North Carolina has made the decision to provide KI to those residents that live within a 10 mile radius of a nuclear power plant. Each county will be responsible for its distribution. Mecklenburg County anticipates distribution in the fall, 2002. The state's new KI website can be found at http://www.dhhs.state.nc.us/dph/ki.htm

This periodical is written and distributed quarterly by the Communicable Disease Control Program of the Mecklenburg County Health Department for the purpose of updating the medical community in the activities of Communicable Disease Control. Program members include: Health Director—Peter Safir; Medical Director—Dr. Stephen R. Keener; Director, CD Control—Carmel Clements; Program Chief, CD Control—Wanda Locklear; CD Control nurses—Nancy Hill, Jane Hoffman, Lorraine Houser, Gail Mills, Monica O'Lenic, Elizabeth Quinn; TB Outreach nurses—Marcia Frechette (also Adult Day Health), Faye Lilieholm; Child Care nurse—Betty Zusin; Rabies/Zoonosis Control—Al Piercy; Program Chief STD/HIV Surveillance—Carlos McCoy; Syphilis Coordinator— Ann White; DIS—Mary Ann Curtis, Michael Rogers, Levon Sessoms; Outreach/Phlebotomist—Teresa Able; Regional Surveillance Team—Bobby Kennedy, Belinda Worsham; Office Assistants—Linda Kalman, Lisa Sealey.

Lorraine Houser, Editor

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Inside This Issue:

Communicable Disease Control *UPDATE*

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